THE MAINE SUPREME JUDICIAL COURT

SITTING AS THE LAW COURT

Cum-18-445

CAROL A. KENNELLY
Appellee,

v.

MID COAST HOSPITAL
Appellant.

ON APPEAL FROM

SUPERIOR COURT (CUMBERLAND)

BRIEF FOR APPELLANT MID COAST HOSPITAL

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STATEMENT OF FACTS

Defendant Mid Coast Hospital (hereinafter "Mid Coast") takes this interlocutory appeal from an order requiring Mid Coast to produce to the plaintiff[1] and her attorneys for use in this public action the medical records of fifty nonparty patients, as well as the personnel file and credentialing information of a nonparty physician.

On November 16, 2016, the plaintiff filed a notice of claim alleging that Mia Marietta, M.D., negligently transected the plaintiff's common hepatic duct while performing a laparoscopic cholecystectomy on September 2, 2015. (A. 55.) "A laparoscopic cholecystectomy is a surgery during which a doctor removes the gallbladder. This procedure uses several small cuts instead of one large one. A laparoscope, a narrow tube with a camera, is inserted through one incision, allowing the doctor to see the gallbladder on a screen." (A. 55 n.1.) The plaintiff's sole claim against Mid Coast was that it was vicariously liable for Dr. Marietta's actions, as it was her employer at the time of the surgery. (A. 55-56.)

The matter proceeded through the prelitigation screening process as required by Maine law. *See* 24 M.R.S. § 2853. As part of that process, Dr. Marietta was deposed and asked about her operative note and its description of the procedure at

[1] Mid Coast has been informed that Ms. Kennelly has passed away. Mid Coast will reference the plaintiff as "the plaintiff" in this brief. At filing, a substitute plaintiff has not been named.

issue. (A. 67-74.) Dr. Marietta was questioned extensively on the steps she took during the plaintiff's procedure, and throughout her testimony she referenced the operative note that she dictated after the surgery as the accurate description of what occurred during the procedure. (A. 68 (Tr. 47) ("Q: And if we look at your operative note in Ms. Kennelly's case, your operative note is consistent with what your practice was, which is to dictate things in sequential order, correct? A. Yes."); *see also* A. 68-72.)

Consistent with her operative note, Dr. Marietta testified that she took down omental adhesions in the interior abdominal wall, which permitted her to see part of the gallbladder, which was swollen, discolored, and bloody appearing. (A. 68 (Tr. 47-49).) She then took down more omental adhesions and was able to see most of the gallbladder, including a stone emanating from the neck and the infundibulum. (A. 68 (Tr. 49-50).) The gallbladder was difficult to grasp, which she described is a common issue, but she eventually was able to grasp it. (A. 68-69 (Tr. 50-51).) She placed three trocars and continued to work at taking down the omental adhesions, and then she identified what she believed to be the cystic duct. (A. 69 (Tr. 51-52).) Before she saw the duct, she created a window to view or clarify the anatomy (A. 69 (Tr. 52)), which she described as follows:

> So my goal, as is a practice of many, is once I have identified what I believe to be the duct, I want to ensure that it is, in fact, the duct. So the steps I take are when you're looking at a gallbladder prior to the start of any dissection, there's a lot of connective tissue both in the front and

> the back and on the sides and what have you, and so this is typically avascular, meaning there's no blood supply or there's very little blood supply, and so it is amenable to gentle dissection through a combination of blunt dissection with instruments and electrocautery; and so in my mind it's essential to clear the area of that tissue in order to ascertain beyond any uncertainty that the structure is what I believe the structure to be.

(A. 69 (Tr. 53).) After she had done this and believed she had identified the cystic duct, she placed clips proximally and distally on the duct and cut partially across the duct. (A. 69 (Tr. 53-54).) She then placed additional clips proximally and distally "to minimize chance of backleak" (A. 70 (Tr. 55)) and continued with the procedure (A. 70-72 (Tr. 55-66)).

Dr. Marietta testified that she came to understand during the course of the lawsuit that the plaintiff's claim was that she had transected the plaintiff's common hepatic duct when she believed she was transecting the cystic duct. (A. 73 (Tr. 121).) When asked about what safety precautions she took, she reiterated:

> A: All right. So I identified the cystic duct--you know, to the best of my knowledge, I identified the cystic duct/gallbladder junction and removed all tissue in proximity such that all that was seen to my eyes was the cystic duct, gallbladder junction, and the liver.
> Q: And at that point you then clipped and transected what you believed was the cystic duct?
> A: I did, as I've described, yes.

(A. 86-87 (Tr. 150-51).)

Dr. Marietta agreed unequivocally that she believes her operative note reflects what she did during surgery:

Q. Do you believe that your operative note is accurate?
A. I do.
Q. And consistent with what you actually did during your surgery?
A. I do.

(A. 73-74 (Tr. 122-23).) Dr. Marietta was clear; her operative note contained a detailed description of the steps she took during the plaintiff's surgery. (*See* A. 67-74.)

Although a surgeon acting within the standard of care may transect the common hepatic duct, the plaintiff maintains that Dr. Marietta was negligent in her treatment of the plaintiff. Among other claims, the plaintiff claims that Dr. Marietta was negligent because she failed to use the "critical view of safety" technique before she attempted to transect the plaintiff's cystic duct. (A. 20, 27-29, 31, 34, 37-38.)

On January 24, 2018, the prelitigation screening phase culminated with a panel hearing. (*See* A. 66, 77.) The panel unanimously found in favor of Dr. Marietta and Mid Coast, concluding that neither was negligent, and that they did not proximately cause the injury complained of by the plaintiff. (A. 66.)

Following the panel's unanimous decision in favor of Dr. Marietta and Mid Coast, the plaintiff filed a complaint, dated January 29, 2018, alleging a sole count of medical negligence against only Mid Coast; the plaintiff did *not* name Dr. Marietta as a defendant in the civil suit. (A. 18-21.) The sole basis for the one count of vicarious liability was that which was stated in the notice of claim. (*See* A. 18-21.)

During the discovery process, the plaintiff made three requests at issue in this appeal. First, the plaintiff requested "[t]he operative notes for the fifty (50) laparoscopic cholecystectomies that Dr. Marietta performed prior to Carol Kennelly's laparoscopic cholecystectomy on September 2, 2015 with the names and identifying information for the individual patients redacted to preserve patient confidentiality." (A. 23.) She requested the same of the fifty laparoscopic cholecystectomies performed by Dr. Marietta after the plaintiff's procedure. (A. 23.) Plaintiff subsequently reduced each of these requests to twenty-five surgeries, for a total of fifty records. (A. 23.)

Second, the plaintiff requested "[t]he complete personnel file for Mia Marietta, M.D. including but not limited to all documents relating to application, hiring, employee benefits, job description, employee reviews." (A. 23.) Third, the plaintiff requested "[a]ll documents in [Mid Coast's] possession, custody, or control relating to the training and/or continuing medical education of Mia Marietta, M.D," and "[a]ny and all documents submitted by Mia Marietta, M.D. to Mid Coast Hospital showing continuing education credits earned between 2011 and 2015." (A. 24.)

Mid Coast objected to providing these records. (A. 23-24.) The plaintiff requested judicial resolution of the issue pursuant to Rule 26(g). (A. 22.) The trial court (*L. Walker, J.*) ordered the parties to file written arguments regarding the

discovery dispute by July 30, 2018, and ordered that the clerk would thereafter schedule a telephonic conference between the court and parties. (A. 3.)

The parties filed their written arguments on July 30, and the court held the telephonic conference on August 30, 2018. (A. 3-4.) The conference was not recorded, and so no transcript is provided on appeal. (A. 4.) On October 15, the trial court entered its order. (A. 4.) The court ordered Mid Coast to "produce Dr. Marietta's personnel file, training materials, and continuing medical education materials." (A. 16.) Further, the court ordered Mid Coast to produce the fifty requested medical records, subject to the following:

> Each redacted record shall include only the year of the surgery, the name of the surgeon (Dr. Marietta), the name of the procedure, and a portion of the section labeled "operative procedure[.]" . . . The "operative procedure section shall be provided only to the point in the surgery where the gallbladder was removed. To the extent there is any identifying information (*e.g.*, name, date of birth, age, sex, race) in the "operative procedure" section, such information shall also be redacted.

(A. 16.)

Regarding the medical records, the trial court concluded that the records, when redacted as ordered, are "not . . . protected from disclosure by the MHSA or HIPAA" (A. 9), are not protected by the physician-patient privilege (A. 11), are relevant to the plaintiff's claim (A. 13), and are not unduly burdensome for Mid Coast to produce (A. 13).

Regarding the personnel file, the court concluded that plaintiff should not be

required to seek the records from Dr. Marietta herself (A. 14), that the personnel file was relevant to the plaintiff's claim (A. 15), and that the entire file should be produced, subject to Mid Coast's ability to claim any privileged material pursuant to M.R. Civ. P. 26(b)(5)(A) (A. 14). Regarding the training and continuing medical education materials, the court concluded that any materials that were "'created for purposes other than professional competence review activity' and are 'available from a source other than a professional competence committee,'" those materials were discoverable (A. 15 (quoting 24 M.R.S. § 2502(8)) and relevant to plaintiff's claim (A. 16).

Mid Coast timely appealed. (*See* A. 4.) The plaintiff filed a motion to dismiss the appeal, arguing that it was interlocutory and that no exception to the final judgment rule applied. (Appellee Carol A. Kennelly's Mot. to Dismiss Appeal pp. 3-11.) Mid Coast opposed the motion and argued that both the collateral order exception and the death knell exception applied to the discovery order at issue. (Appellant's Objection to Motion to Dismiss Appeal pp. 3-15.) This Court (Humphrey, J.) unequivocally denied the motion to dismiss. (Order on Mot. to Dismiss Appeal p. 1.) Because the Court denied the motion, Mid Coast does not address the justiciability of the appeal further in its brief.

STATEMENT OF THE ISSUES

1. Whether the court erred by ordering Mid Coast to produce to the plaintiff and her counsel the operative notes from fifty laparoscopic cholecystectomy procedures performed on nonparty patients.
2. Whether the court erred by ordering Mid Coast to produce to the plaintiff and her counsel the personnel file of a nonparty former employee.
3. Whether the court erred by ordering Mid Coast to produce to the plaintiff and her counsel materials from the credentialing file of a nonparty former employee.

SUMMARY OF THE ARGUMENT

Here, the court abused its discretion in its ordering the production of nonparty patient records in four ways. First, the court clearly erred when it determined that the records were relevant to this medical malpractice action when they will not tend to make any fact of the surgery at issue more or less probable. Further, the removal of certain patient information from these records renders them useless; it would be unduly prejudicial to compel the production of these records and then not allow Dr. Marietta to explain what she did during these procedures on other patients, testimony that would require discussing and examining specific information about nonparty patients. Second, the records are protected by the physician-patient privilege and are therefore exempt from discovery. Removing certain identifying

information from the communication does not remove the patient—or the privilege protections—from the communication. Third, Mid Coast would have to violate the statutory privacy rights of those fifty nonparty patients to comply with the order. Information is not divested of its protected status simply by removing certain information. Fourth and finally, the court abused its discretion when it declined to protect Mid Coast from the administrative burden of complying with this discovery order. Not only is there an administrative burden if Mid Coast is required to comply with the Court's Order here, but, undoubtedly, if this Court allows such requests to go forward, then plaintiffs will routinely request the medical records of other patients who received similar treatment in order to attempt to establish a breach in the standard of care, opening the floodgates for numerous future requests.

The court also abused its discretion in the discovery order when it ordered Mid Coast to produce Dr. Marietta's entire personnel file, save for certain privileged materials. The court abused its discretion when it ordered Mid Coast to produce a file that Mid Coast is statutorily required to keep confidential, rather than requiring the plaintiff to seek the file from Dr. Marietta herself.

Finally, the court abused its discretion when it ordered Mid Coast to produce the training and continuing medical education materials of Dr. Marietta because all of those materials are privileged and protected from discovery as they are only collected and retained as part of the credentialing process.

ARGUMENT

1. The court erred by ordering Mid Coast to produce to the plaintiff and her counsel the partially redacted operative notes from fifty laparoscopic cholecystectomy procedures performed on nonparty patients.

The trial court clearly erred when it determined that operative notes of fifty nonparty patients were relevant to the instant case, and abused its discretion when it ordered Mid Coast to produce those records to the plaintiff and her counsel for use in her public case. Mid Coast will address, in this order: the irrelevancy of those records, the physician-patient privilege protecting those records, the state and federal statutes further protecting those records, and the administrative burden on Mid Coast to comply with the court's discovery order.

i. Nonparty patient medical records are irrelevant and not reasonably calculated to lead to the discovery of admissible evidence.

The Maine Rules of Civil Procedure permit discovery only of documents that are not privileged and that are "relevant to the subject matter involved in the pending action." M.R. Civ. P. 26(b)(1). The information requested must be "reasonably calculated to lead to the discovery of admissible evidence." *Id.* Pursuant to M.R. Evid. 401, "[e]vidence is relevant if: . . . [i]t has any tendency to make a fact more or less probable than it would be without the evidence; and . . . [t]he fact is of consequence in determining the action." Generally, prior statements or actions are not relevant if "they do not deal with or relate to the conduct in" the case at issue.

See Jacob v. Kippax, 2011 ME 1, ¶ 18, 10 A.3d 1159; *see also State v. Jordan*, 1997 ME 101, ¶ 7, 694 A.2d 929.

Decisions regarding the relevance of requested discovery are reviewed for clear error, *Jacob*, 2011 ME 1, ¶ 14, 10 A. 3d 1159, and discovery orders are reviewed for an abuse of discretion, *Selby v. Cumberland Cnty.*, 2002 ME 80, ¶ 12 n. 11, 796 A.2d 678. The interpretation of a statute, however, is reviewed de novo. *Medical Mutual Ins. Co. of Maine v Bureau of Ins.*, 2005 ME 12, ¶ 5, 866 A.2d 117. Here, the trial court clearly erred when it ruled that the medical records were relevant to the plaintiff's case, and it abused its discretion when it compelled Mid Coast to produce them because Dr. Marietta's testimony demonstrates that her operative note was a complete description of the procedure at issue (*see* A. 67-74), and her documentation related to surgeries performed on nonparty patients has no tendency to make it more or less likely that she met the standard of care in her treatment of the plaintiff.

As discussed above, the plaintiff's sole claim in this case is that Mid Coast is liable for its former employee Dr. Marietta's professional negligence. The plaintiff wrote in her written argument: "Plaintiff's central argument in this case is that Dr. Marietta failed to obtain the [critical view of safety or] CVS before cutting [the plaintiff's] biliary anatomy. Dr. Marietta testified that she did not generally follow the CVS technique; instead opting for her own method she called 'Mia Marietta's

critical view.' [The plaintiff] is entitled to discovery reasonably calculated to explore whether Dr. Marietta actually followed her standard practice during [the plaintiff's] surgery." (A. 31 (internal record citation omitted).) The flaw with the plaintiff's request, however, is that Dr. Marietta testified that, regardless of what she may have done in surgeries before or following the plaintiff's, her operative note describes the steps she took during the plaintiff's surgery. (A. 73-74 (Tr. 122-23).) Therefore, it does not matter what her standard practice is—it just matters what she did during *the plaintiff's* procedure.

The legal tenet that prior acts by a provider regarding other patients have "no probative value" in a subsequent case involving a different patient is not new, nor is it novel.[2] *See Jacob*, 2011 ME 1, ¶ 18, 10 A.3d 1159 (quoting *Jordan*, 1997 ME 101, ¶ 7, 694 A.2d 929).[3] The burden for a plaintiff in a medical malpractice case has long been for the plaintiff to establish "(1) the appropriate standard of medical care, (2) the defendant's deviation from that recognized standard, and (3) that the conduct in

[2] Indeed, in *Cummins v. United States*, a case cited by the plaintiff in the trial court (A. 99), Judge Nivison recognized that when the issue in a medical malpractice case is whether a provider's care of a specific patient satisfied the applicable standard of care, "[t]he quality of [the provider's] job performance on other occasions is not necessarily pertinent to issues in this case." (A. 100.)

[3] In *Jacob v. Kippax*, the plaintiff-patient sought to introduce at trial a consent agreement signed by the defendant-dentist in a disciplinary action, admitting that he had "repeatedly failed to document procedures, removed teeth not designated by the referring dentist, discharged patients without proper evaluation, allowed the unlicensed practice of dentistry by assistants, and failed to reassess patient complaints of pain." 2011 ME 1, ¶ 7, 10 A.3d 1159. The patient sued the dentist for alleged negligence in his performance of a biopsy and for failing to obtain her informed consent. *Id.* ¶ 14. The Law Court affirmed the trial court's refusal to admit the agreement in evidence and held that the dentist's admissions there were not relevant. *Id.* ¶ 18.

violation of that standard was the proximate cause of the plaintiff's injury." *Ouellette v. Mehalic*, 534 A.2d 1331, 1332 (Me. 1988). How Dr. Marietta performed *other* laparoscopic cholecystectomies on *other* patients has no bearing on (1) what the standard of care is in this case, (2) whether she breached the standard of care in this case, or (3) whether any breach was the proximate cause of the alleged damages in this case.

Here, in performing surgery on the plaintiff, Dr. Marietta testified that her operative note accurately reflected what she did in the plaintiff's surgery. (A. 73-74 (Tr. 122-23).) Medical negligence looks at the case at issue in a vacuum. This is not a situation where Dr. Marietta seeks to testify about her routine or standard practice in order to supplement the records or her memory of what occurred during surgery.[4] *Cf. Jacob*, 2011 ME 1, ¶¶ 22-23, 10 A.3d 1159. The way in which Dr. Marietta performs surgeries on different patients does not mean that discovery regarding these nonparties is permissible; if it were, then requests for nonparty patient medical information would be made in every medical malpractice matter. For example, emergency physicians may routinely preliminarily read the radiology films they order; surgeons may always review a check-list of identifying information before starting surgery; and nurses may conduct vitals at certain time intervals. Just because

[4] Notably, even if Dr. Marietta was relying on her routine or standard practices, the records would still not be admissible for the reasons addressed below.

a provider has a certain practice does not mean that discovery should be permitted to determine if the provider acted in conformity with that practice, especially where a provider has testified that the medical records provide a complete explanation of the provided care. Dr. Marietta's operative note describes how she operated on the plaintiff, and her testimony demonstrates that her operative note was a complete description of the procedure at issue (*see* A. 67-74). Whether Dr. Marietta has used the same or different techniques in *other* cases is irrelevant to *this* case. *See id.* ¶ 18. The plaintiff has stated that her central argument is that Dr. Marietta did not obtain the critical view of safety (A. 31); the use of the nonparty medical records that the plaintiff seeks are irrelevant to what Dr. Marietta did during the plaintiff's surgery.

Further, Rule 26(b)(1) requires that the discovery request be "reasonably calculated to lead to the discovery of admissible evidence." Because the plaintiff would be forbidden to learn the identities of the nonparty patients or to otherwise attempt to contact those patients (A. 16), this discovery request is calculated only to learn parts of the contents of the operative notes themselves. Even if this Court disagrees with Mid Coast's position that the notes are irrelevant, one is hard-pressed to think of any instance in which these notes could be admitted in evidence at any trial, as the prejudicial effect of the notes would outweigh any probative value to such an extent that admission would always be barred under Maine Rule of Evidence 403. The reality is that any probative value that the notes may have would be gutted

and their prejudicial effect heightened because Dr. Marietta could not testify to any differences in her treatment of the nonparty patients as compared to her treatment of the plaintiff, because any testimony about what made their cases different would require her to testify to information that would make the subject patient of the note identifiable (such as gender, age, medical history, anatomical anomalies, or comorbidities, for example). *See infra, Part iii.* As Dr. Marietta repeatedly made clear in her deposition testimony, different patients needing a laparoscopic cholecystectomy will present with different characteristics, and those characteristics may direct Dr. Marietta's approach during treatment or may cause differing results. (Tr. 48 ("Q: And in this surgery, Dr. Marietta, the goal initially is to uncover the—the infundibulum of the gallbladder, correct? A: I think it depends on, number one, your surgical approach; it depends on the anatomy that presents itself to you when you are initially inspecting the area."); Tr. 62 ("But in a case with a lot of disease or sometimes coupled with someone's inherent anatomy, the gallbladder can be more fused to the liver bed, and when you disrupt around the liver—it's called a capsule, and if you disrupt that, it tends to bleed.").)

Given the legal standard in a medical malpractice case, the contents of the operative notes of nonparty patients would be highly prejudicial and their probative value minimal if Dr. Marietta could not testify about her treatment of these nonparty patients. Thus, to the question present in the discovery phase (is the request

reasonably calculated to lead to admissible evidence?), the answer is no. Taking together the legal standard in a medical malpractice action, the principal recognized in *Jacob* and other cases, and Rule 403's test, the evidence requested is not relevant, and the request is not reasonably calculated to lead to the discovery of admissible evidence.

ii. Regardless of redaction, nonparty operative notes are protected by the physician-patient privilege and are exempt from discovery.

Even if this Court determines that the medical records are relevant and are reasonably calculated to lead to the discovery of admissible evidence, that does not affect the privileged nature of the records. *See, e.g.*, *Stark v. Hartt Transp. Sys., Inc.*, No. 2:12-CV-195-NT, 2013 WL 358266, at *10 (D. Me. Jan. 28, 2013) ("The fact that the plaintiff's mental health records are relevant—even potentially highly relevant and valuable to the defense—does not suffice to overcome the federal psychotherapist-patient privilege.") This Court reviews the "nature and scope" of a privilege de novo. *Harris Mgmt., Inc. v. Coulombe*, 2016 ME 166, ¶ 12, 151 A.3d 7. For the reasons discussed in this section, the physician-patient privilege applies to the records sought by the plaintiff, and the trial court erred in ordering Mid Coast to produce those records.

The Maine Rules of Evidence grant a patient with the privilege

> to refuse to disclose, and to prevent any other person from disclosing, confidential communications made for the purpose of diagnosing or treating the patient's physical . . . condition, . . . between or among the

> patient and . . . [t]he patient's health care professional, . . . and . . . [t]hose who were participating in the diagnosis or treatment at the direction of the health care . . . professional.

M.R. Evid. 503(b).

In the instant case, Mid Coast claims the privilege on behalf of the fifty unnamed, unnoticed patients who are unable to assert the privilege or otherwise challenge the disclosure of their medical records. *See* M.R. Evid. 503(d) (health care professional has the "authority to claim the privilege on behalf of the patient"); Field & Murray, *Maine Evidence* § 503.3 at 227 (6th ed. 2007) ("[The privilege" may be claimed on [the patient's] behalf by the physician or psychotherapist at the time of the communication."); *id.* at 227 n. 62 ("Rule 503 does not give the doctor any affirmative rights to disclose information protected by professional duty of confidentiality.").

Maine's rule on physician-patient privilege does not expressly define the term "communication." *See* M.R. Evid. 503(a). It does define that

> [a] communication is 'confidential' if it is not intended to be disclosed to any third persons, other than . . . [t]hose who were present to further the interests of the patient in the consultation, examination, or interview; . . . [t]hose who were reasonably necessary to make the communication; or . . . [t]hose who are participating in the diagnosis and/or treatment under the direction of the health care . . . professional.

M.R. Evid. 503(a)(5).

A common-sense reading of Rule 503 demonstrates that the operative notes from a laparoscopic cholecystectomy surgery are confidential communications

protected by the privilege. The note itself is a written summary from the surgeon that communicates to the patient and to others participating in the patient's treatment what occurred during the procedure, which is a part of the patient's treatment (or, in the case of some surgeries, part of the diagnosing process). Thus, the note is a "confidential communication" as defined by Rule 503. *See also State v. Tracy*, 2010 ME 27, ¶ 16, 991 A.2d 821 ("When a statement is cloaked in confidentiality, it is intended that the statement may only be disclosed to an outside party—including the court—*to further the purpose of the communication* or for other limited purposes *related to the service being provided*." (Emphasis added)).

Further, a long-recognized purpose of the privilege is to encourage "the patient freely to disclose all matter which may aid in the diagnosis and treatment of disease and injury," such that the patient is "secure . . . from disclosure in court of potentially embarrassing private details concerning health and bodily function." 1 McCormick on Evid. § 98 (7th ed.); *see also* Field & Murray, Maine Evidence § 501.1 at 206 (6th ed. 2007) ("Rules of privilege are designed to keep out some portion of the truth in order to foster relationships that as a matter of social policy are deemed to deserve protection.") A more recently recognized purpose is in "supporting the creation of a private enclave that enables the patient to make informed, independent choices among medical options." 1 McCormick on Evid. § 98. The privilege is meant to encourage people to seek medical assistance and to

have a private relationship with their providers. This is especially true for the vulnerable members of our community; candidness with healthcare providers should be encouraged, not discouraged. Just as a patient might be slow to share accurate information with his doctor if he feared it would be revealed to a third party for use in a public trial, so too might he be slow to partake in a procedure if he thought that his medical records may be made public without his knowledge or permission.

Although a matter of first impression for this Court, other courts have concluded that redacted records retain their privileged status, and for sound reason. An illuminative example is *Roe v. Planned Parenthood Southwest Ohio Region*, 912 N.E.2d 61 (Ohio 2009). There, parents of a minor who received an abortion from a Planned Parenthood facility sought the medical records of nonparty patients who had received similar treatment from the facility. *Id.* at 64. Planned Parenthood refused, and asserted the privilege on behalf of the nonparty patients. *Id.* at 64-65. The Supreme Court of Ohio held that the records were privileged and exempted from discovery, and that redaction of identifying information from the records did not alter the privileged status of the records. *Id.* at 71. The Court held: "**Redaction of personal information, however, does not divest the privileged status of confidential records.** Redaction is merely a tool that a court may use to safeguard the personal, identifying information within confidential records that have become subject to disclosure either by waiver or by an exception." *Id.* (bold emphasis added.)

Likewise, the Appellate Court of Illinois considered an order in a medical malpractice suit for a hospital to provide the discharge records of nonparty patients, with names and identifying numbers redacted. *Parkson v. Cent. DuPage Hosp.*, 435 N.E.2d 140, 141 (Ill. 1982). The court held that the nonparty records were protected by the physician-patient privilege, regardless of the instruction that certain information be redacted. *Id.* at 143-44. The court stated:

> Whether the patients' identities would remain confidential by the exclusion of their names and identifying numbers is questionable at best. The patients' admit and discharge summaries arguably contain histories of the patients' prior and present medical conditions, information that in the cumulative can make the possibility of recognition very high. As the patients disclosed this information with an expectation of privacy, their rights to confidentiality should be protected.

Id. at 144 (internal citation omitted); *see also Glassman v. St. Joseph Hosp.*, 631 N.E.2d 1186, 1198 (Ill. 1994) ("Even with the deletion of identifying numbers along with names, the patients' confidentiality may be compromised.")

The Court of Appeals of Texas also considered whether privileged information could be redacted from a medical record, leaving the remainder of the document unprivileged. *In re Columbia Valley Reg'l Med. Ctr.*, 41 S.W.3d 797, 800 (Tex. App. 2001). The patient-plaintiff sought nonparty medical records with all information redacted save for a specific provider's charting customs. *Id.* The court stated that "[o]nce it is established that a document contains a confidential communication, the privilege extends to the entire document," and further noted that

the information related to the provider's charting custom "in fact, [remained] related to the treatment of the patient." *Id.* at 801. The court held that the physician-patient privilege protected the records from disclosure, regardless of any redactions. *Id.* at 801-02.

Other courts have held similarly. *See Baker v. Oakwood Hosp. Corp.*, 608 N.W.2d 823, 830 (Mich. App. 2000) (noting no "exception for redacted medical records" in the Michigan privilege and "conclud[ing] that the privilege applies even where the patient names are not disclosed"); *Buckman v. Verazin*, 54 A.3d 956 (Pa. Super. Ct. 2012) ("The information relating to third parties that have not given their consent is confidential and is not relevant to the instant negligence claim in that actions taken by [the doctor] when operating on other patients is not probative of what his actions were when caring for [the patient-plaintiff]."); *Ortiz v. Ikeda*, No. C.A. 99C-10-032-JTV, 2001 WL 660107, at *1 (Del. Super. Ct. Mar. 26, 2001) ("Because the scope of discovery does not extend to documents protected by the physician-patient privilege, names redacted or not, the requested discovery will not be ordered in this case.").

The cases relied upon by the plaintiff and trial court would have this Court conclude that a patient no longer has a privilege to maintain the confidentiality of his or her records if the patient's "identifying information" is ordered redacted from the confidential record—it ignores the circumstances of the record's creation, the

purpose of the privilege, and the fact that the privilege continues to exist in spite of the redaction.

For these reasons, the physician-patient privilege recognized by M.R. Evid. 503(b) applies to the nonparty patient records at issue in this case, regardless of whether they are redacted, and they are not subject to discovery under Rule 26. Thus, the trial court abused its discretion in its discovery order.

iii. The nonparty medical records are protected by state and federal privacy laws, and removal of certain information from the records does not divest the records of their protected status.

The court further abused its discretion in its discovery order because the medical records are protected by Maine law and the federal Health Insurance Portability and Accountability Act of 1996 (hereinafter HIPPA).

This Court reviews de novo the construction of a statute. *Medical Mut. Ins. Co. of Maine*, 2005 ME 12, ¶ 5, 866 A.2d 117. In interpreting a statute, this Court "look[s] first to the statute's plain language to give effect to the Legislature's intent, considering the language in the context of the whole statutory scheme to avoid absurd, illogical, or inconsistent results." *Kennebec Cty. v. Me. Pub. Employees Ret. Sys.*, 2014 ME 26, ¶ 20, 86 A.3d 1204 (quotation marks omitted). Here, to adopt the trial court's interpretation of the Maine and federal statutes protecting these records would lead to an illogical result.

Pursuant to 22 M.R.S. § 1711-C(2), a patient's health care information is confidential and may not be disclosed to anyone other than the patient, with limited exceptions. In relevant part, section 1711-C(1)(E) defines "health care information" as

> information that directly identifies the individual and that relates to an individual's physical, mental or behavioral condition, personal or family medical history or medical treatment or the health care provided to that individual. "Health care information" does not include information that protects the anonymity of the individual by means of encryption or encoding of individual identifiers or information pertaining to or derived from federally sponsored, authorized or regulated research governed by 21 Code of Federal Regulations, Parts 50 and 56 and 45 Code of Federal Regulations, Part 46, to the extent that such information is used in a manner that protects the identification of individuals.

Section 1711-C(1)(E) charges the Maine Health Data Organization (hereinafter MHDO) with "adopt[ing] rules to define health care information that directly identifies an individual." The MHDO's definition specifies twenty-five categories of information,[5] including a catch-all provision of "[a]ny other unique

[5] 90-590 C.M.R. ch. 125, § 3 (2009) defines as "Identifying Information":

> A. Patient's Name;
> B. Names of Patient's Family Members;
> C. Insured's Name;
> D. Patient's or Insured's Address;
> E. Patient's or Insured's Telephone or FAX Numbers. Includes both home and work numbers;
> F. Patient Control Number. A unique alphanumeric number assigned by a health care provider to facilitate retrieval of individual financial records and posting of payment;
> G. Medical Record Number. A number assigned to the patient's medical/health record by the provider;
> H. Patient's Account Number. A unique number used by a health care provider or supplier to identify an individual's case records and for posting payment;

number, *characteristic*, code, or information that is a direct identifier." 90-590 C.M.R. ch. 125, § 3 (2009) (emphasis added).

Without question, an unredacted copy of the operative note would qualify as health care information. *See id.* The plaintiff argues, however, that redaction removes the operative notes from this definition. This argument would render the plain language of the statute meaningless. The information in nonparty patient operative notes was collected and maintained in order to document the care provided to an individual and identifiable patient. The document contains *both* patient identifiers and substantive information regarding the care provided to the patient—it is health care information. It does not become "not health care information" simply because the description of the procedure is separated from the information identifying the patient. Indeed, removing a patient's name or other such information from an operative note does not mean that it is no longer her operative note.

I. Patient's or Insured's Social Security Number;
J. Insured's Unique Health Insurance Identification Number;
K. Insured's Unique Health Insurance Certificate Number;
L. Patient's Medicare/Medicaid Health Insurance Identification Number;
M. Patient's Federal Employees Compensation Act Number;
N. Patient's or Insured's Credit Card Number;
O. Patient's or Insured's Bank Account Number;
P. Patient's or Insured's Operator's License Number;
Q. Patient's or Insured's Vehicle Registration Number;
R. Patient's or Insured's Vehicle License Plate Number;
S. Patient's or Insured's Vehicle Identification Number;
T. Patient's or Insured's Finger or Voice Prints;
U. Patient's or Insured's Photographic Images;
V. Patient's Pilot Medical Certificate Number;
W. Patient's Maine Department of Corrections Inmate Identification Number;
X. Patient's or Insured's Medical Device Identifiers and Serial Numbers; and
Y. Any other unique number, characteristic, code or information that is a direct identifier.

The inability to truly de-identify a medical record is especially true in a state like Maine and a geographic area like the one served by Mid Coast Hospital. Even if certain characteristics are redacted, no provider can know whether a particular detail (for example, an anatomical anomaly noted in an operative note or the timeframe of a procedure) will allow the identity of a patient to be discovered.

Turning to federal protections, HIPAA also protects against unauthorized disclosure of "individually identifiable health information." 42 U.S.C. § 1320d-6. HIPAA defines "health information" as

> any information, whether oral or recorded in any form or medium, that--
> (A) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
>
> (B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

42 U.S.C. § 1320d(4).

The Department of Health and Human Services's regulations regarding the disclosure of HIPAA's protected health information also require the stringent removal of a substantial amount of information. 45 C.F.R. § 164.514.[6]

[6] The regulation states, in pertinent part:

> (b) Implementation specifications: requirements for de-identification of protected health information. A covered entity may determine that health information is not individually identifiable health information only if:
> (1) A person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods for rendering information not individually identifiable:

As discussed above, ordering the redactions of certain information does not ensure compliance with the federal regulations. Given the population of the State of Maine, one is not hard-pressed to come up with a scenario where information

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(i) Applying such principles and methods, determines that the risk is very small that the information could be used, alone or in combination with other reasonably available information, by an anticipated recipient to identify an individual who is a subject of the information; and

(ii) Documents the methods and results of the analysis that justify such determination; or

(2)(i) The following identifiers of the individual or of relatives, employers, or household members of the individual, are removed:

(A) Names;

(B) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

(1) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and

(2) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

(C) All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

(D) Telephone numbers;

(E) Fax numbers;

(F) Electronic mail addresses;

(G) Social security numbers;

(H) Medical record numbers;

(I) Health plan beneficiary numbers;

(J) Account numbers;

(K) Certificate/license numbers;

(L) Vehicle identifiers and serial numbers, including license plate numbers;

(M) Device identifiers and serial numbers;

(N) Web Universal Resource Locators (URLs);

(O) Internet Protocol (IP) address numbers;

(P) Biometric identifiers, including finger and voice prints;

(Q) Full face photographic images and any comparable images; and

(R) Any other unique identifying number, characteristic, or code, except as permitted by paragraph (c) of this section; and

[2](ii) The covered entity does not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.

45 C.F.R. § 164.514(b).

contained in an operative note for a patient may include one or more unique characteristics that would identify said patient, especially given that the approximate date and type of surgery would be known, as would the surgeon. Mid Coast hospital is in Brunswick, Maine. At trial, the world of people who had laparoscopic cholecystectomies at Mid Coast, performed by Dr. Marietta, in 2015, is small. This becomes even more apparent when considering the other permissible questions that can be asked of Dr. Marietta that may narrow that group further, such as: how frequently did you perform this procedure? (A. 83-84 (wherein plaintiff's counsel questioned Dr. Marietta about how often she performed laparoscopic cholecystectomies in the year of the plaintiff's surgery).) Given Dr. Marietta's testimony that she performed upwards of 150 laparoscopic cholecystectomies in the year 2015 (A. 83), this would mean that the twenty-five most recent surgeries on either side of the plaintiff's would likely fall within three months or less of the date of the plaintiff's surgery. As such, even if the trial court is, on its face, complying with the federal regulations, in effect, privacy is not being maintained. *See e.g.* 45 C.F.R. § 164.514(b)(2)(i)(C) (requiring the removal of "[a]ll elements of dates (except year) . . . for dates . . . including admission"). This, of course, is magnified when considering the reality that if said notes were produced, Dr. Marietta would need to explain why she performed each surgery the way in which she did, which would have the likely outcome of needing to discuss a nonparty patient's gender,

age, comorbidities, medical history, and outcome—all of which are specifically prohibited by the law.

The trial court's interpretation of section 1711-C and HIPAA leads to the illogical result that Mid Coast must produce (irrelevant) operative notes, despite the inability to truly de-identify nonparty patients' identifying information as required by the law. For these reasons, the trial court abused its discretion in the discovery order when it concluded that these state and federal protections did not apply to the medical records at issue in this case and ordered them disclosed.

iv. The court should have exercised its power under Rule 26(c) to protect Mid Coast from the administrative burden of complying with the plaintiff's discovery request.

It would also be unduly burdensome for Mid Coast to retrieve the fifty nonparty patient records and attempt to redact "any identifying information" as ordered by the trial court (A. 16). Not only would there be an administrative burden if Mid Coast is made to produce these records as ordered, but there would be an ineffable burden placed upon the hospital-patient relationship if Mid Coast and other health care entities are required to begin producing the medical records of nonparty patients for use in civil actions.

Rule 26(c) permits a party to request that the court order "that the discovery not be had" to protect the party from "undue burden or expense," among other things. "The power of the court under this rule shall be exercised with liberality toward the

accomplishment of its purpose to protect parties and witnesses." M.R. Civ. P. 26(c); *see also* F.R. Civ. P. 26(b)(1) (contemplating that discovery should be "proportional to the needs of the case"). In exercising its power under Maine Rule 26(c) "with liberality toward the accomplishment of its purpose to protect parties and witnesses," courts should consider whether the burden of production and the value of the requested discovery (if any) is proportional to the needs of the case.

The time investment for Mid Coast to produce these records cannot be understated. If Mid Coast is ordered to produce the records, then it has to (1) conduct a search for the fifty laparoscopic cholecystectomies, that is not narrowed by date, but by number, and then (2) assign someone to go through each of the patients' records in order to identify the operative notes, and then, (3) after locating the operative notes, Mid Coast will have to assign someone to ensure that appropriate redactions are made, and then, (4) given the importance of the redactions, all would need to be double checked and verified by legal representatives. The time investment for this project alone is a matter of days, and it is foreseeable that if such requests become routine for plaintiffs, which they surely will, other requests could include far more than 50 records, further enhancing the time and labor burden (and healthcare administration costs) into the future.

The potential exposure for significant liability for the disclosure of protected information also cannot be discounted if medical providers are ordered to produce

redacted nonparty patient records for use in public litigation. *E.g.*, 45 U.S.C. § 1320d-6(b)(1) (listing penalties for disclosure, including up to a $50,000 fine and/or up to one year of imprisonment); *see also Amente v. Newman*, 653 So.2d 1030, 1033 (Fla. 1995) (Overton, J., concurring). As was aptly put by the concurring Judge in *Amente*:

> the mere fact that a judge authorized the discovery of the medical records of non-party patients does not, under my reading of this opinion, immunize the parties from invasion-of-privacy claims by the non-party patients if the medical records are disclosed in such a manner that the identities of the non-party patients are revealed. If the identity of such a patient is revealed, whether directly, indirectly, or inadvertently, a claim for invasion of privacy could be established despite the existence of the court-ordered discovery. Furthermore, in addition to a civil suit by the non-party patients, the attorneys and parties may be subject to sanctions imposed by the court.

Id.

The burden placed upon Mid Coast by the court's discovery order is grossly disproportionate to the needs of the case, given the irrelevancy of the records and the low likelihood that their production would lead to the discovery of admissible evidence. *See supra, Part i*. Given the significant administrative burden of retrieving, redacting, and producing the records requested by the plaintiff, the low likelihood that the records would be admissible, and the significant protections associated with such confidential records, the trial court's order was an abuse of discretion under Rule 26(c).

2. <u>The court erred by ordering Mid Coast to produce the personnel file of a nonparty former employee.</u>

The trial court abused its discretion in the discovery order when it ordered Mid Coast to produce all nonprivileged material in Dr. Marietta's personnel file because such material is confidential by statute.[7]

Maine law mandates that an employer "take adequate steps to ensure the integrity and confidentiality of [an employee's] records." 26 M.R.S. § 631. The law also provides, however, that an employer must "provide, at no cost to the employee, one copy of the entire personnel file when requested by the employee or former employee." *Id.* Common sense demonstrates the necessity for this statute: not dissimilar from protecting a nonparty's medical records, a nonparty's personnel file should also be protected from disclosure in litigation by the former employer. If an appropriate request is made for the personnel file to the *employee*, via subpoena or otherwise, the employee can then respond or object as she sees fit. Assuming, then, that the material in the file is subject to discovery, the employee can be ordered to request the personnel file from her employer, who can release the file to the employee without violating section 631. It should not be incumbent upon Maine employers to advance arguments on behalf of their current or former employees,

[7] The trial court did correctly order that any professional competence review records and any records pertaining to sentinel events that might otherwise fall under the plaintiff's discovery request are protected by statute and not subject to discovery. (A. 14.)

when those employees are in a better position to decide whether to contest disclosing the contents of the file or objecting to the discovery request.

In ordering the production of Dr. Marietta's personnel file, the trial court cited *Pinkham v. Dep't of Transp.*, 2016 ME 74, 139 A.3d 904, for the proposition that a record's confidentiality is irrelevant to the court's analysis under Rule 26. The records at issue in *Pinkham* were portions of an appraisal report prepared for the Maine Department of Transportation in an eminent domain case. *Id.* ¶¶ 1-3. By statute, appraisal records in the possession of the Maine Department of Transportation and the Maine Turnpike Authority are confidential until "9 months after the completion date of the project according to the record of the department or Maine Turnpike Authority," at which point they become public records; further, "records of claims that have been appealed to the Superior Court are public records following the award of the court." 23 M.R.S. § 63(3). Of great apparent importance to this Court's analysis in *Pinkham* was that the legislative bar on disclosing the appraisal records falling under section 63 was related to Maine's Freedom of Access Act. 2016 ME 74, ¶¶ 6-11, 139 A.3d 904. To the contrary, many records falling under section 631 do not qualify as public records pursuant to the Freedom of Access Act. *See* 1 M.R.S. § 402(3).

Here, Dr. Marietta's personnel file is confidential, 26 M.R.S. § 631, and is not subject to public access, *see* 1 M.R.S. § 402(3). For reasons unknown, the plaintiff

did not make Dr. Marietta a party to this civil suit and seeks to compel Mid Coast to produce Dr. Marietta's confidential records, rather than seeking these records from Dr. Marietta herself. *Cf. Burnett v. Ocean Properties, Ltd.*, 2017 WL 3262163, * 5 (D. Me. July 31, 2017) (considering 26 M.R.S. § 631, in light of federal precedent, and quashing a subpoena directing a plaintiff-employee's current employer to produce employee's records, and ordering the plaintiff-employee to produce those records himself). Here, too, the plaintiff should be required to seek these records from Dr. Marietta through a subpoena, rather than asking Mid Coast to violate the confidentiality that section 631 provides to such records.

For these reasons, the trial court abused its discretion by ordering Mid Coast to produce the file, rather than requiring the plaintiff to subpoena the file from Dr. Marietta herself. *See Burnett*, 2017 WL 3262163 at * 5.

3. <u>The court erred by ordering Mid Coast to produce the materials from the credentialing file of a nonparty former employee.</u>

The trial court clearly erred when it found that Dr. Marietta's training and continuing education materials were relevant to this case. Further, the court abused its discretion by ordering Mid Coast to produce those materials when it misinterpreted the statute and assumed, for reasons unknown and not apparent in the record, that the requested materials were created for purposes other than as a professional competence review activity, and that they are available from another source.

This Court interprets a statute de novo, *Medical Mut. Ins. Co. of Maine*, 2005 ME 12, ¶ 5, 866 A.2d 117, and "look[s] first to the statute's plain language to give effect to the Legislature's intent, considering the language in the context of the whole statutory scheme to avoid absurd, illogical, or inconsistent results." *Kennebec Cty.*, 2014 ME 26, ¶ 20, 86 A.3d 1204 (quotation marks omitted).

The credentialing materials at issue, as requested by the plaintiff, are "[a]ll documents in [Mid Coast's] possession, custody, or control relating to the training and/or continuing medical education of Mia Marietta, M.D," and "[a]ny and all documents submitted by Mia Marietta, M.D. to Mid Coast Hospital showing continuing education credits earned between 2011 and 2015." (A. 24.)

The plaintiff has not alleged that Dr. Marietta was not a properly trained physician, and the limited inquiry in this case is how Dr. Marietta treated the plaintiff. *See Jacob*, 2011 ME 1, ¶ 18, 10 A.3d 1159. Therefore, the trial court erred when it determined that the training materials had some tendency to make it more or less likely that she met the standard of care in her treatment of the plaintiff. *See* M.R. Civ. P. 26(b)(1); M.R. Evid. 401.

Further, even if the Court determines that the records are relevant, as Mid Coast argued to the trial court, any records in the possession, custody, or control of Mid Coast relating to Dr. Marietta's training and continuing education credits were only collected as part of its statutorily mandated duties under the Maine Health

Security Act (hereinafter MHSA), *see* 24 M.R.S. §§ 2501-2511, and are therefore privileged from discovery in this action. As Mid Coast informed the trial court, Mid Coast collects and maintains the materials requested by the plaintiff solely as part of its duties under the MHSA; i.e. a professional competence review process. *Id.; see also* 32 M.R.S. § 3296 (mandating that reviews of qualifications of medical providers are confidential and are exempt from discovery).[8]

The MHSA requires that hospitals hire and extend privileges only to physicians who meet threshold requirements of "training, experience, and professional competence." 24 M.R.S. § 2503(2). It further requires that hospitals put in place processes for insuring quality review, handling patient grievances, tracking negative outcomes, and providing education programs. *Id.* § 2503(3). The MHSA also makes professional competence review records collected as part of section 2503 processes confidential and not subject to discovery; it further makes these records inadmissible in court. 24 M.R.S. § 2510-A ("all professional competence review

[8] 32 M.R.S. § 3296 states, in pertinent part:

> All proceedings and records of proceedings concerning medical staff reviews, hospital reviews and other reviews of medical care conducted by committees of physicians and other health care personnel on behalf of hospitals located within the State or on behalf of individual physicians, when the reviews are required by state or federal law, rule or as a condition of accreditation by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association Committee on Hospital Accreditation or are conducted under the auspices of the state or county professional society to which the physician belongs, *are confidential and are exempt from discovery.*

(Emphasis added.)

records are privileged and confidential and are not subject to discovery . . . and are not admissible as evidence in any civil, judicial or administrative proceeding. Information contained in professional competence review records is not admissible at trial . . . ."); *see also* 24 M.R.S. § 2510(3). "Professional competence review records' is defined to include "the minutes, files, notes, records, reports, statements, memoranda, data bases, proceedings, findings and work product prepared at the request of or generated by a professional competence review committee relating to professional competence review activity." 24 M.R.S. § 2502(8). The statute carves out from the definition of professional competence review records those records that would otherwise meet the definition but "are individual medical or clinical records or any other record that was created for purposes other than professional competence review activity and is available from a source other than a professional competence committee." *Id.*

Here, the information requested by the plaintiff is the professional competence information that Mid Coast only collected, created, or received related to the training or continuing medical education of Dr. Marietta (including any documents from her showing her continuing education credits) in furtherance of its credentialing and privileging process. This information is explicitly protected by MHSA.

To the extent that the Court considers plaintiff's argument that the requested records were created for a different purpose or available from other sources,

Mid Coast submits that there is no such evidence on the record, and it was error for the trial court to assume as much. By way of example, if the record were relevant and otherwise admissible, and the plaintiff obtained the record by searching the internet, subpoenaing a non-party, or engaging in other discovery measures, the fact that the hospital had relied on the same document during its professional competence review activity would not shield the document from admission at trial. In the instant case, however, the trial court's interpretation leads to the illogical result that Mid Coast is tasked with demonstrating what it cannot: that a document is not available from some other source or created for some other unknown reason. Instead, Mid Coast put forth to the court the information that it could: that any such records in Mid Coast's possession were solely created or collected pursuant to MHSA. The trial court's interpretation of section 2502 leads to an illogical result: it puts the onus on the hospital to prove a negative—i.e. that the records do not exist elsewhere or were not created for some purpose besides the purposes for which the hospital requested or received them—in order to maintain the privilege against discovery under MHSA.

This Court has noted that the Legislature has made some "statutory privilege[s] against discovery in litigation explicit," *Maine Health Care Ass'n Workers' Comp. Fund v. Superintendent of Ins.*, 2009 ME 5, ¶ 10 n. 6, 962 A.2d 968 (referencing 24 M.R.S. § 2510-A), and Maine's Superior Court has repeatedly

upheld the absolute nature of the privileges set out by the MHSA. *E.g. Headrick v St. Mary's Hosp.*, No. CV-94290, 1995 WL 18036759 (Me. Super. Jan. 21, 1995); *see also Marshall v. Spectrum Medical Group*, 198 FRD 1, 4 n.2 (D. Me. 2000) (noting of section 2510-A that "the trial courts in Maine have recognized the broad scope of the 'nondiscoverability' provision").

Of note is the Superior Court case *Headrick v St. Mary's Hospital*. There, the court (Saufley, J.) was presented with a patient-plaintiff's motion to compel a hospital to produce records within the hospital's possession related to a particular provider. 1995 WL 18036759 at *1. The hospital argued that "all of the documents it ha[d] gathered, maintained, and created regarding [the doctor's] performance, privileging, peer review, and quality review [were] confidential and may not be released in the context of th[e] proceeding." *Id.* at *2. The court reviewed both 32 M.R.S. § 3296 and 24 M.R.S. § 2510(3), applying both to the records in issue. *Id.* While the court recognized the plaintiff's concern that her case depended upon production of the records, the court addressed the policy reasons behind the nondisclosure provisions:

> While plaintiff's argument is compelling, such policy considerations have been weighed and addressed by the Legislature. *A general public policy of encouraging hospitals to engage in regular detailed review of the physician practices within the hospital has led to nationwide legislation requiring peer review and quality review committees within almost every hospital.* Both Congress and state legislators have shielded the information gathered and created in the course of such reviews from discovery in civil law suits. The public policy concern behind such a

> shield is the fear that, in the absence of confidentiality, physicians and hospital administrators would not only be reluctant to honestly review and discuss physician's actions, but would fail to make full and complete records of those reviews. Faced with such difficult policy considerations, both state and federal governments have adopted much more restrictive confidentiality provisions allowing and encouraging full and complete review of physician's skills and actions without the threat that information obtained and created in those reviews would be made available in litigation. It is in this light that the court reviews the request made by plaintiff to have access to the documents held by [the hospital].

Id. (emphases added) (internal citations omitted) (citing 42 U.S.C. § 11101, *et se*q; 24 M.R.S.A. § 2503; 42 U.S.C. § 11137; 32 M.R.S.A. § 3296).

As Mid Coast pointed out in its written argument to the trial court, if the requested records *do* exist elsewhere, the plaintiff is free to attempt to discover them. Mid Coast has been clear that it only obtains and maintains any records like those requested by the plaintiff pursuant to its duties under MHSA, and its records are thus protected and privileged from disclosure by statute. Therefore, the trial court abused its discretion when it ordered Mid Coast to produce the records.

CONCLUSION

For these reasons, Mid Coast respectfully requests that this Court vacate the discovery order and remand for further proceedings.

Dated at Portland, Maine this 14th day of January, 2019.

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CERTIFICATE OF SERVICE

I, Abigail C. Varga, Esq., attorney for the Appellant, hereby certify that I have, on this day, **delivered by electronic mail and by United States mail**, postage prepaid, a copy of the foregoing Brief for Appellant Mid Coast Hospital to:

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Dated at Portland, Maine, this 14th day of January, 2019.

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